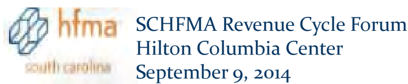
The Revenue Cycle Leader's Role in Controlling Contract Profitability

Presented by: Kelley Regan, Esq. & Linda Fotheringill, Esq.

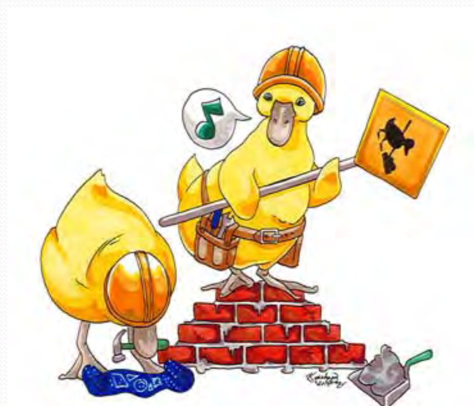


SCHFMA Revenue Cycle Forum
Hilton Columbia Center
September 9, 2014

Workshop Scope & Objectives

1) Introduce a tool Hospital leaders can utilize for best practice contract evaluations.

2) Interactive Workshop!



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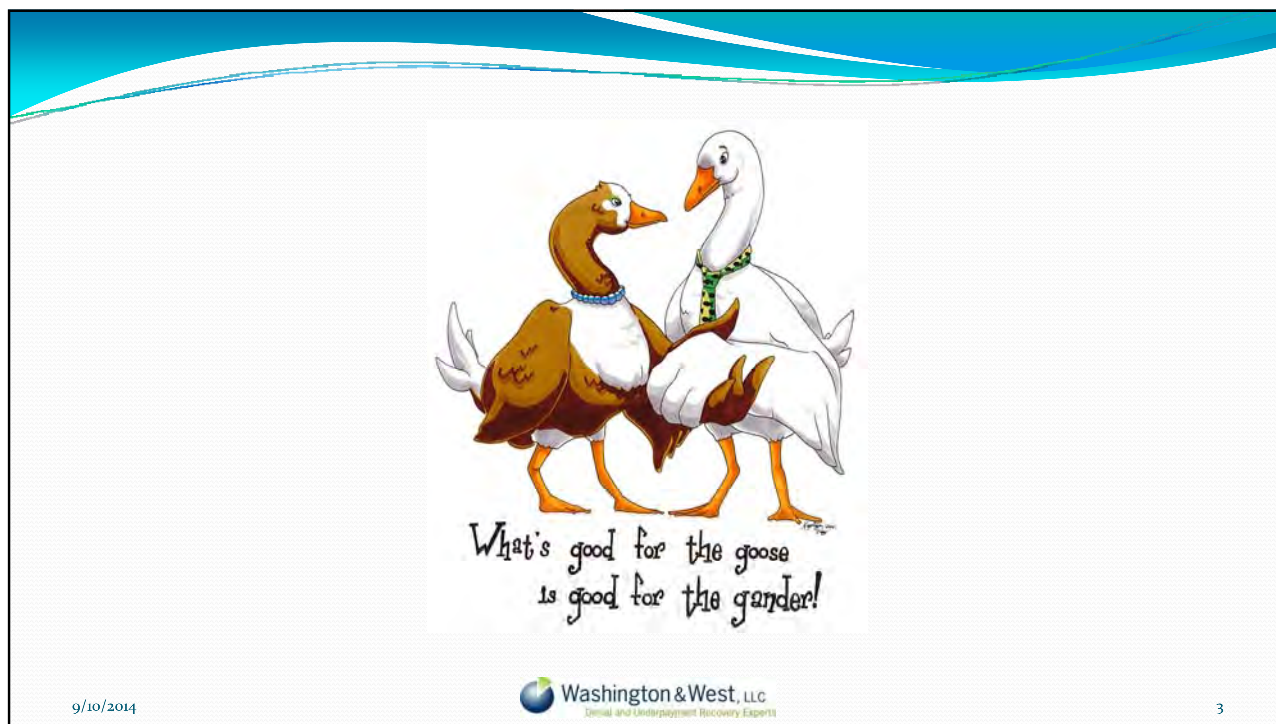
What's good for the goose
is good for the gander!
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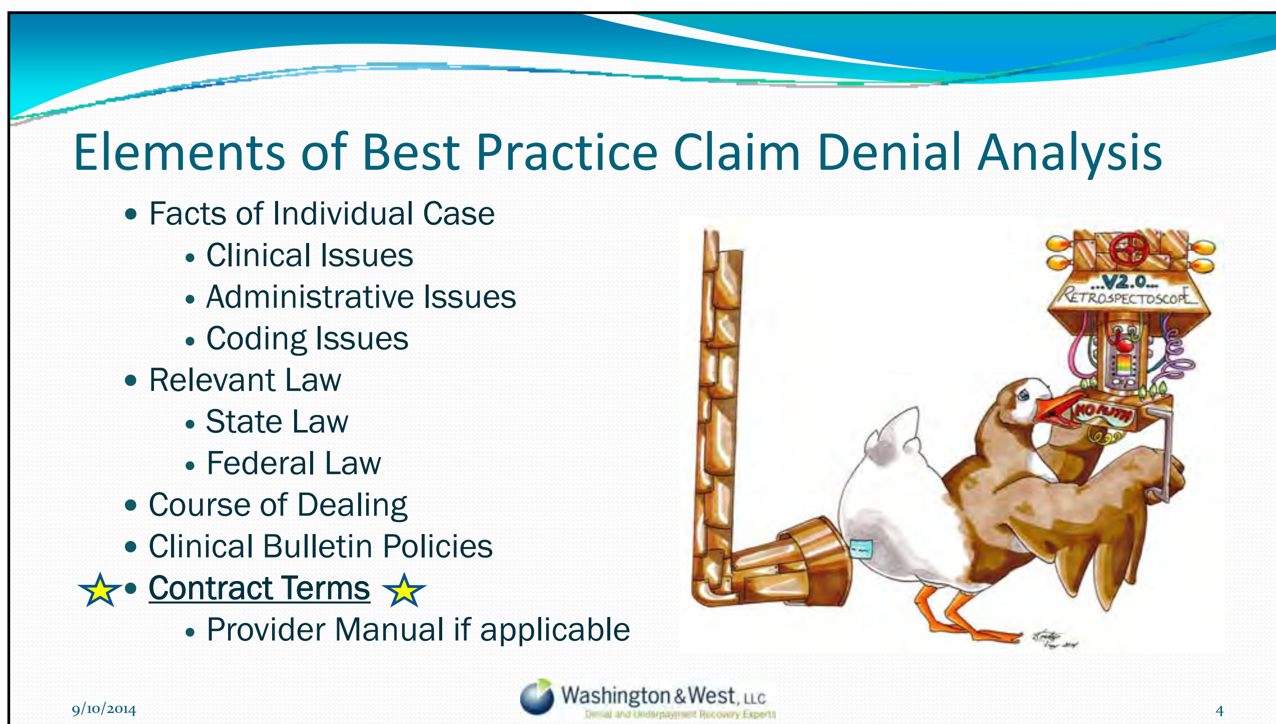
Elements of Best Practice Claim Denial Analysis
• Facts of Individual Case
• Clinical Issues
• Administrative Issues
• Coding Issues
• Relevant Law
• State Law
• Federal Law
• Course of Dealing
• Clinical Bulletin Policies
• Contract Terms
• Provider Manual if applicable
...V2.0...
Retrospectoscope
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Contracts and Health Law

There are state and/or federal laws on these denial issues:

- Authorization
  - Modification of authorization, delivery/newborn, emergency services
- Claims submission
  - Minimum timeframes
- Prompt payment
  - Definition of clean claim, payment time frames, interest penalty
- Mis-verification of benefits
- Internal/External Appeals
- Subrogation
- Retroactive denials/ Retractions
- Notice prejudice
- Lien laws
- Pre-existing conditions
- Emergency Services
  - State law definitions, EMTALA
- Continuation of Benefits
- ERISA
- Coordination of benefits
- Automatic newborn coverage
- Experimental treatment
  - Workers compensation, Third Party Liability

South Carolina Law: Look-Back Limit

"An insurer **may not initiate** overpayment recovery efforts **more than eighteen (18) months** after the initial payment was received by the provider [except for fraud, required by a self-insured plan, or required by a state or federal government program]." SC Code, Title 38, Ch. 59, § 250(B).

- Contracting for more than 18 months is not permissible, but…
- You could contract for less than 18 months!

Six-Step Best Practice Contract Evaluation

Step 1: Distribute complete contract & provider manual to Department Directors

Step 2: Directors identify requirements for each Department

Step 3: Departments determine whether requirements are achievable with current resources

Step 4: Departments determine whether or not requirements are fair

Step 5: Departments analyze cost of meeting requirements

Step 6: Directors recommend actions or changes to CFO, CEO, and Managed Care

Contract Evaluation Example: Provider Manual

Payor shall compensate Hospital for Covered Services provided to Members in accordance with the provisions and procedures set forth in applicable Product Addendum(a) attached hereto and incorporated herein and in accordance with the Provider Manual and applicable law.

Administrative and operational procedures regarding the policies and procedures of PAYOR are set forth in the Provider Manual, as amended from time to time. PAYOR shall provide thirty (30) days prior written notice of any material changes.

Evaluation Example: Provider Manual

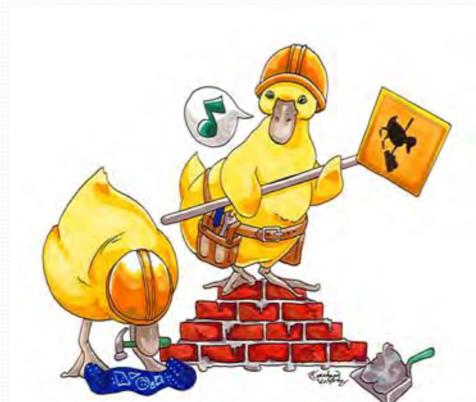
1. Requirements?
2. Achievable?
3. Fair?
4. Cost?
5. Recommendations?

1. Abide by terms of Manual, revised from "time to time."
2. No – Manual is 200 pages & cannot be reviewed daily for changes.
3. No – Can't abide by unknown, variable terms.
4. Unknown – the sky's the limit!
5. If Manual must be incorporated into Contract, then print out & attach to Contract & no changes without written acceptance by designated executive at Hospital.

Workshop!

Interactive Workshop using best practice contract evaluations!

1) Verification of Benefits
2) Authorization
3) Authorization
4) Medical Necessity
5) Readmission
6) Claim Submission
7) Appeal Timely Filing
8) Dispute Resolution



#1 Verification of Benefits

Hospital acknowledges that such information provided by Payor is subject to change retroactively under the following circumstances: (1) if Payor has not yet received information that an individual is no longer a Customer; (2) if the individual's Benefits Plan is terminated retroactively for any reason including, but not limited to, non-payment premium; (3) as a result of the Customer's final decision regarding continuation of coverage pursuant to state and federal laws; or (4) if eligibility information Payor receives is later proven to be false. Payor will make reasonable efforts to cause Payor to process eligibility changes within 90 days.

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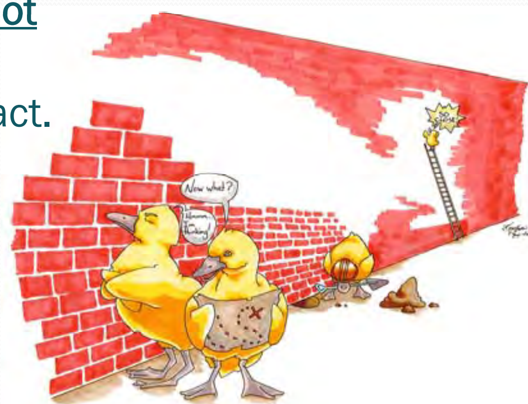
#1 Appeal Strategies

- Turn the tables…show Payor did not make "reasonable efforts" and acted inconsistent with the contract.
- Request documentation/information.
- Detrimental Reliance.



#2 Authorization

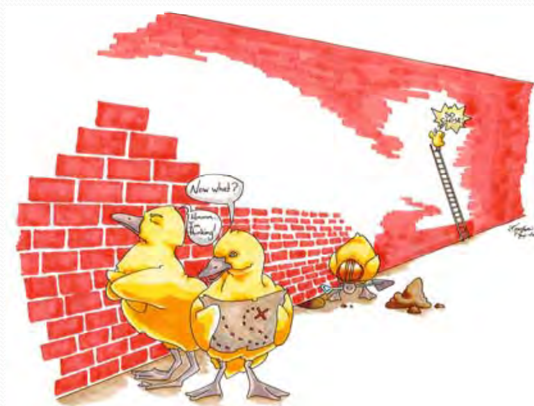
Hospital must request authorization for services from Payor by telephone prior to providing any services to a Member, regardless of the time of day or day of week or the requirements of the Benefit Contract regarding prior authorization. All Services provided to Members by Hospital must be prior authorized by Payor, and confirmed by Payor in writing. Only Emergency Health Services will be eligible for retroactive authorization at the sole discretion of Payor.

#2 Authorization

Hospital must request authorization for services from Payor by **telephone** prior to providing any services to a Member, regardless of the time of **day or day of week** or the requirements of the Benefit Contract regarding prior authorization. All Services provided to Members by Hospital must be prior authorized by Payor, and **confirmed by Payor in writing.** Only Emergency Health Services will be eligible for retroactive authorization at the sole discretion of Payor.

#2 Appeal Strategies

- Establish that the services provided were an emergency!
- Hospital can have an emergency even when patient does not come in through the Emergency Department.
- Establish unreasonable not to provide authorization at time of contact.
- Extenuating Circumstances.



#3 Authorization

Payor shall not deny or reduce payment for any Medically Necessary Covered Services based on Hospital's failure to comply with any administrative or notification requirements...

In the event that the lack of authorization resulted from action or inaction by Payor or by Hospital, then Payor shall reimburse Hospital for all Medically Necessary Covered Services rendered to this Member.

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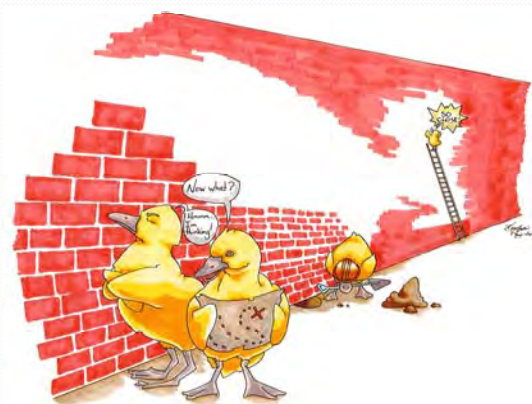
#3 Appeal Strategies

- Timely appeal.
- Appeal proving medical necessity and appropriate level of care of the services rendered.
- Is Payor withholding authorizations?



#4 Medical Necessity

The decision as to whether a service or supply is Medically Necessary for purposes of payment rests with the Medical Director or his/her designee, provided however, that such decisions shall be based on standard criteria published by Milliman & Robertson, or such other reputable national guidelines as Corporation in its sole discretion employ.

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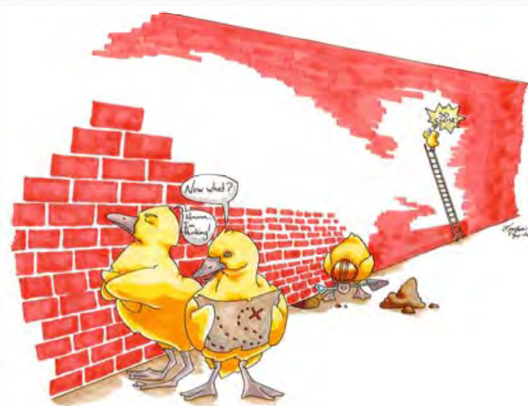
#4 Appeal Strategies

- Appeal showing services met Milliman & Robertson criteria, if you can, and...
- Guidelines like Milliman have a disclaimer: meant to be a screening tool and not a substitute for clinical judgment.
- If "other reputable national" guidelines were cited, demand copy and argue that national guidelines were met.
- Did a qualified Physician actually weigh in on decision?



#5 Readmission

Cases that are readmitted to the Hospital's inpatient facility within fourteen (14) days for the same episode of care are not eligible for two payments. For this policy the same episode of care will not include similar diagnoses or those admissions for chronic disease management where the standard of care would warrant readmission within fourteen (14) days.

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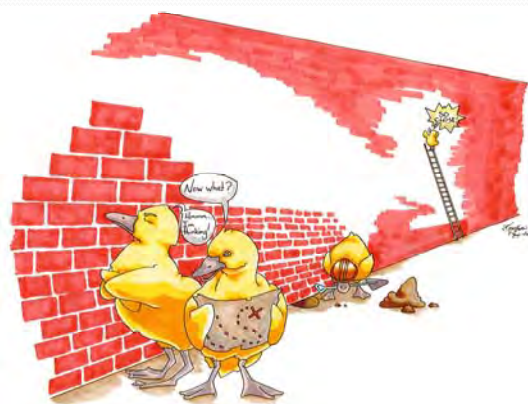
#5 Appeal Strategies

- Appeal showing the 2nd admission was not the "same" episode of care and/or was for a "chronic diseases management" admission.
- Show at end of 1st admission, patient was medically stable for discharge.
- Show 2nd admission not preventable.



#6 Claim Submission

Claims must be received by Payor within three hundred sixty five days (365) following the latter of the date of service or the Member's discharge...

Notwithstanding the foregoing, for situations involving coordination of benefits ("COB") if Hospital could not reasonably have known that Payor was responsible for payment within the initial three hundred sixty five (365) days, then within ninety (90) days following the date that the Hospital learned that Payor was responsible for payment.

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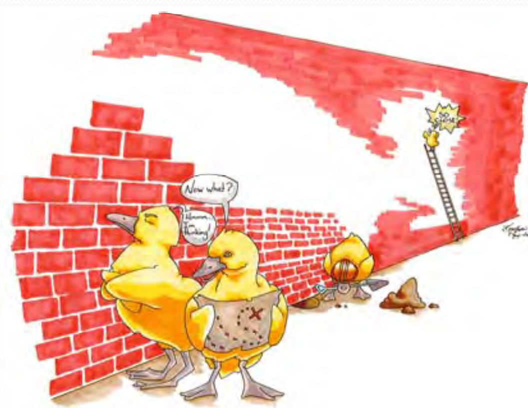
#6 Appeal Strategies

- Appeal showing proof of timely
- If untimely, argue extenuating circumstances.
- If coordination of benefits issue, submit proof of other insurer(s) coverage/denial.
- If contract silent, argue unlimited timeframe for corrected claims.



#7 Appeal Timely Filing

Appeals must be submitted to payor within the required timeframes. All level one appeals must be initiated within 180 calendar days of payor's initial decision. Appeals filed after that date will not be considered. If Hospital is dissatisfied with payor's decision then Hospital has 30 calendar days from the date of payor's decision on the initial appeal to file a level two appeal.

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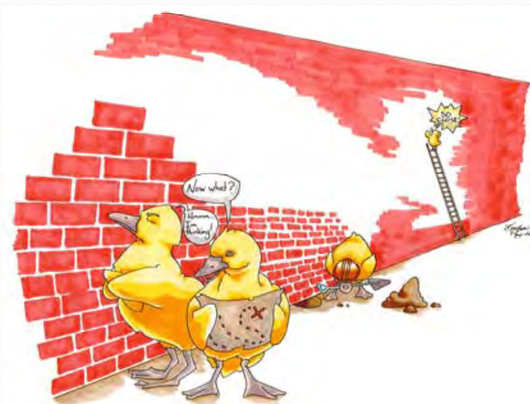
#7 Appeal Strategy

- Show proof of timely filing to Payor.
- If untimely, show extenuating circumstances.
- Show Payor fault in not getting decision promptly to you making timely 2nd appeal impossible.



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#8 Dispute Resolution

If parties cannot resolve a dispute arising under this contract informally, the parties shall enter into binding arbitration before a single arbitrator selected by mutual agreement. Such arbitrator shall be a member of the American Arbitration Association (AAA), and such arbitration shall be conducted pursuant to the rules of AAA then in effect.

Meanwhile, in the provider manual…

A complaint or appeal related to a clinical decision/denial is considered a member appeal. Member appeals must be filed within 30 days of the notice of action that Payor took to reduce, suspend, limit, terminate or deny a service.

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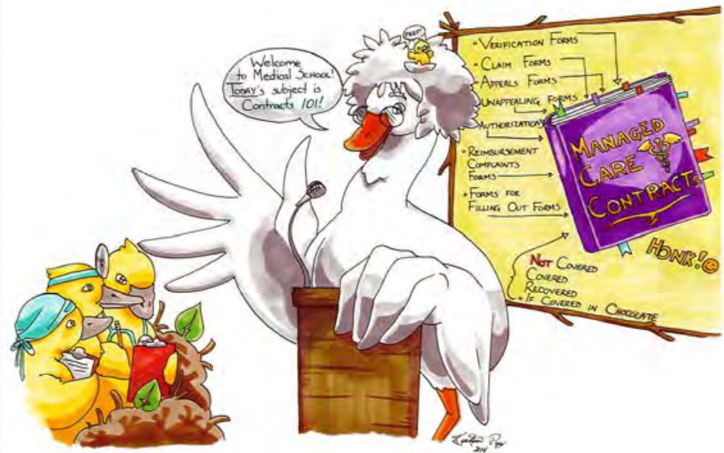
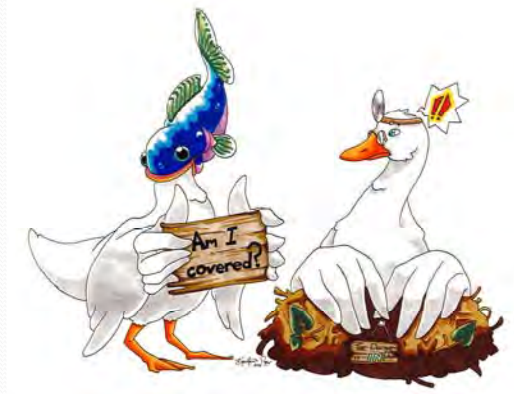
Contract Terms Bottom Line

- A Provider can negotiate for the best possible rates, but payment will be subject to contract terms, leaving Provider open to potentially unlimited revenue loss.



Thank You For Your Attention!
Questions? Comments?



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